

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1617

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Millington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
TOWN <u>Millington</u>		TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>JONAS</u> (First) <u>BOLLINGER</u> (Middle) <u>BOLLINGER</u> (Last)		4. DATE OF DEATH <u>February 26, 1951</u> (Month) (Day) (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-18-1864</u>
9. AGE last birthday <u>86</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Ta.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Emanuel Bollinger</u>	
14. MOTHER'S MAIDEN NAME <u>Eliz Weiskin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give way or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>George T. Bollinger, Elkton, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cancer of Head of Pancreas

Antecedent cause(s)

(b) —
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(c) —II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION —

21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>		

22. I hereby certify that I attended the deceased from Jan 22, 1951, to Feb 20, 1951, that I last saw the deceased alive on Feb 20, 1951, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. W. HamiltonM.D.Millington Md.Feb 26/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Lillian</u>	LOCATION (City, town, or county) <u>Woodstock</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Edward Fellows</u>	24. FUNERAL DIRECTOR <u>Henry Pippin</u>	ADDRESS <u>Elkton, Md.</u>	

290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1951
G. H. HALL V. P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1618

1. PLACE OF DEATH: COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md.</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ELIZA</u> (First) <u>JANE</u> (Middle) <u>BROOKS</u> (Last)		4. DATE OF DEATH <u>Feb. 24</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 22/1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Mira Wilmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Henry Brooks</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Chronic myocardial insufficiency</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>	<u>8-10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u>	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>—</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u> (COUNTY) <u>—</u> (STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>

22. I hereby certify that I attended the deceased from Feb 5, 1951, to Feb 23, 1951, that I last saw the deceased alive on Feb 23, 1951, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE H. H. Hamilton (Degree or title) M.D. ADDRESS Millington, Md. DATE SIGNED Feb 26/51

23. BURIAL CREMATION <u>Burial</u> (Specify)	DATE THEREOF <u>Feb 27/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Millington</u>	LOCATION (City, town, or county) <u>Millington</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Edward Bellows</u>	24. FUNERAL DIRECTOR <u>Edward Bellows</u>	ADDRESS <u>Millington Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Queen Ann</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>May Burrows</u> (First) (Middle) (Last) <u>Fithian</u>		4. DATE OF DEATH <u>Feb.</u> (Month) (Day) (Year) <u>6</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MARCH 19, 1915</u> 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN D. Burrows</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hosp. Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>(a) Peripheral vascular collapse</u>		<u>30 hrs.</u>
Antecedent cause(s) <u>(b)</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c)</u>		
11. OTHER SIGNIFICANT CONDITIONS <u>Pregnancy - Disproportion - Caesarian section</u>		
19a. DATE OF OPERATION <u>2-4-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Pregnancy</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>		22. PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-4, 1951, to 2-6, 1951, that I last saw the deceased alive on 2-6, 1951, and that death occurred at 12:30 A.M. m., from the causes and on the date stated above.

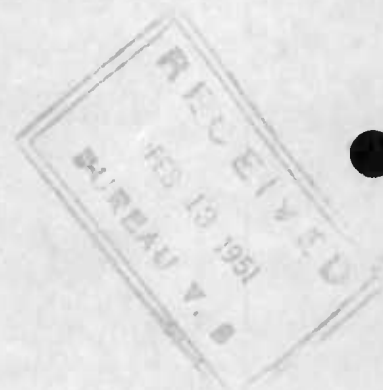
SIGNATURE A.C. Dick (Degree or title) W.D. ADDRESS Chester town, Md DATE SIGNED 2-6-51

23. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>	DATE THEREOF <u>Feb 9 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Silver Lake</u>	LOCATION (City, town, or county) <u>Rock Hall</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>Feb. 9, 1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hill</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition
in #21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1620

CERTIFICATE OF DEATH

Reg. Dist. No. 202

FILE No. G 131 MAR 5 1951

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Queen Anns</u>		STREET ADDRESS (If rural, give location) <u>High Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MATILDA MAY Hessey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 28, 1907</u>
9. AGE last birthday <u>43 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Chestertown, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Department Store</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Hessey</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Hurd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>213-03-4746</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
960X Immediate cause (a) <u>Surgical shock = peripheral</u>			<u>1/2 hour</u>
Antecedent cause(s)			
200c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>vascular collapse</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>2-23-57</u>		19b. MAJOR FINDINGS OF OPERATION <u>Deformation of radial nerve</u> <u>Ununited fracture of rt. humerus</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Accident</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>nr. Rock Hall, Kent. Co. Md.</u>		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-26-49</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>2 automobiles ran together. (3/5/51 - ams)</u>

22. I hereby certify that I attended the deceased from 12-26, 1956, to 2-23, 1957, that I last saw the deceased alive on 2-23, 1957, and that death occurred at 1245 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Feb. 25, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	LOCATION (City, town, or county) <u>Chestertown, Md.</u>	(State)
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DATE REC'D BY LOCAL REG. <u>Feb. 24-1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes.</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>	ADDRESS
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390 646

MARGIN RESERVED FOR BINDING

VS. A15-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH COUNTY <u>Mont</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Galena</u> LENGTH OF STAY (in this place) <u>14 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Galena</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>mt Olivet Hill</u>		STREET ADDRESS (If rural give location) <u>mt Olivet Hill</u>	
3. NAME OF DECEASED (First) <u>Clara</u> (Middle) <u>Retta</u> (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>11</u> (Year) <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 29 1914</u>
9. AGE last birthday <u>36</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Galena Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Alexander Briscoe Sr</u>		14. MOTHER'S MAIDEN NAME <u>Charity Carol</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-20-7273</u>	
17. INFORMANT <u>Harry Johnson (husband)</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Anoxia and Toxemia due to</u>		
Antecedent cause(s) (b) <u>carcinomatosis due to</u>		<u>7 mos</u>
(c) <u>carcinoma of Left Breast</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>July 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>carcinoma of Left Breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>suicide</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1951, to Feb 11, 1951, that I last saw the deceased alive on Feb 11, 1951, and that death occurred at 10 p.m., from the causes and on the date stated above.

SIGNATURE <u>Wallace Oberhain M.D.</u>	ADDRESS <u>Cecilton Md</u>	DATE SIGNED <u>Feb 11, 1951</u>
23. BURIAL, CREMATION, REBURY (Specify) <u>Buried</u>	DATE THEREOF <u>Feb 15 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Olivet Hill Cem.</u>
LOCATION (City, town, or county) <u>Mt. Galena Md.</u>	24. FEDERAL DIRECTOR <u>Edward R. Hallow</u>	ADDRESS <u>Wilmington Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 15, 1951</u>	REGISTRAR'S SIGNATURE <u>Elizabeth J. Mulford</u>	

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1622

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lyndeb</u> <u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent & Queen Anne General</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frank</u> (Middle) <u>Sorrell</u> (Last) <u>Jones</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>13</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MARRIED, WIDOWED , DIVORCED , (Specify)	8. DATE OF BIRTH <u>Aug 8, 1884</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year: Months <u>6</u> Days <u>13</u> Hours <u>57</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming tenant</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Burnell Jones</u>	
14. MOTHER'S MAIDEN NAME <u>Mamie Carroll</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Mrs. Frank Jones, Lyndeb, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

353.3

Antecedent cause(s)

186a

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Fracture, base of skull

(b) Epilepsy or fainting attacks (?)

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 days

20 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>Accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Lyndeb</u>	(COUNTY) <u>Kent</u>	(STATE) <u>md</u>
HOMICIDE	INJURY	TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-11-57 5⁰⁰ m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell down stairs during fainting attacks.</u>

22. I hereby certify that I attended the deceased from 2-11, 1957, to 2-13, 1957, that I last saw the deceased

alive on 2-13, 1957, and that death occurred at 4³⁰ a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL-CREATION REMOVAL (Specify)	DATE THEREOF <u>2/15/57</u>	NAME OF CEMETERY OR CREMATORY <u>Westly Chapel</u>	LOCATION (City, town, or county) <u>Rock Hall, Md.</u>	(State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>Feb. 14, 1957</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> <u>Church Hill, Md.</u>		

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharp St</u>		STREET ADDRESS (If rural, give location) <u>Sharp St</u>	
3. NAME OF DECEASED (Type or Print) <u>Emma</u> (First) <u>Martha</u> (Middle) <u>Mariner</u> (Last)		4. DATE OF DEATH <u>February</u> (Month) <u>6</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 10, 1864</u>
9. AGE last birthday <u>86</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John T. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Martha Emma Swann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Olive Swann, daughter</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Endo-Myocarditis, Hypertension

Antecedent cause(s)

447X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>—</u>		PLACE (Home, farm, factory, street, OF office hdq., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from 2/5, 1951, to 2/6, 1951, that I last saw the deceased alive on 2/5, 1951, and that death occurred at 6:35 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Feb 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>	LOCATION (City, town, or county) <u>Rock Hall, Kent Co., Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 9, 1951</u>		REGISTRAR'S SIGNATURE <u>J. Shwood Ingram</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	
				ADDRESS <u>—</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1624

1. PLACE OF DEATH COUNTY <u>Stent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Betterton</u> COUNTY <u>Stent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Betterton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Betterton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Ericson ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary E Moore</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 4 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Betterton</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James T Greenwood</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Bowers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sub. Ernest Willis Kennedyville Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Paralysis agtamb

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b) nephritis6 mo.(c) Loss of memory

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 1950, to Feb 6, 1951, that I last saw the deceasedalive on Feb 5, 1951, and that death occurred at 5 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

VVV 698



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1625
Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Vernon Ave</u>		STREET ADDRESS <u>Mt. Vernon Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nellie</u> <u>Nicholson</u> <u>Noland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 2, 1951</u> 19	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 6, 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert G. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Amanda Lusby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Conlyn E. Noland Chestertown, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of Breast</u>		<u>5 yrs.</u>
Antecedent cause(s) (b) <u>170x</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>50</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 10, 1950, to Feb. 2, 1951, that I last saw the deceased alive on Feb. 2, 1951, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 4-1951

Clara S. Barnes

J. Willis Wells - Chestertown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 152 APR 16 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location) <u>Boundary ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Julia</u> (Middle) <u>May</u> (Last) <u>Radney</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 19 1879</u>
9. AGE last birthday <u>70 1/2</u> yrs.		10. If under 1 year: Months <u>7</u> Days <u>11</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Herock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Husband</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4-13x Immediate cause

(a) Cerebral hemorrhage, Paralysis

Antecedent cause(s)

92x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension, arteriosclerosis, Chronic Endo-myocarditis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

2 hours

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1950, to Feb 17, 1951, that I last saw the deceased

alive on 2/17, 1951, and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 2/20/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Robert A. Burgard

M.D.

Rock Hall Md

2/20/51

Burial

2/20/51

Wesley Chapel Cemetery

Rock Hall

Kent

Md.

2/20/51

J. Elwood Burgess

Edgar L. Lane

Colonial Hall Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FHM No. G 130 FEB 9 1957 **CERTIFICATE OF DEATH**

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Rock Hall</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kent</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kentland Green Arms</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William J Scott</u>		4. DATE OF DEATH <u>February 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-30-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm hand</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Rock Hall</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Scott</u>		14. MOTHER'S MAIDEN NAME <u>Racheal Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Guard</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Peripheral vascular collapse

INTERVAL BETWEEN ONSET AND DEATH

10 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension + myocarditis, chronic
(c) Arteriosclerotic gangrene right foot

10 years?

5 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

1-31-57

19b. MAJOR FINDINGS OF OPERATION

Arteriosclerotic gangrene of foot

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-9, 1957, to 2-1, 1957, that I last saw the deceased alive on 2-1, 1957, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ad Dick

W.D.

Chestertown, Md

27-57

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

2-3-57

M. E. Cemetery

near Rock Hall

md

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 3-1957

Clara L. Barnes

Edgar L. Lane Church Hill Md

970 116



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1628 201

1. PLACE OF DEATH COUNTY <u>Kent Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Kent</u> COUNTY <u>Still Pond</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Henry</u> (First) <u>Ray</u> (Middle) <u>Simmons</u> (Last)		4. DATE OF DEATH <u>Feb</u> (Month) <u>3</u> (Day) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan 31/1951</u>
9. AGE last birthday <u>2 weeks</u> yrs.		10. AGE last birthday If under 1 year Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clifton Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Mary Redding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>Clara Redding</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Bronchial Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

(b) Cold

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 1, 1957., to Feb 3, 1957., that I last saw the deceased

alive on Feb 3, 1957., and that death occurred at — m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

L. G. Atwell

Still Pond Md

2/4/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 3 1957</u>	<u>Mt Zion Cemetery</u>	<u>Still Pond Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/6/57</u>	<u>E. K. Howard Jones</u>	<u>B. R. Follmer</u>	<u>Still Pond Md</u>	

10121134940V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1961

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1629

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural - Broad Neck</u>		STREET ADDRESS (If rural, give location) <u>Rural - Broad Neck</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles M. Vickers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 2, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 28, 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas J. Vickers</u>		14. MOTHER'S MAIDEN NAME <u>Susan Maslin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Chas. M. Vickers Chestertown, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Congestive Heart Failure</u>		<u>2 weeks</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>		<u>Years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to Feb. 2, 1951, that I last saw the deceased alive on Feb. 1, 1951, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert E. Ennor, M.D. Chestertown 2/3/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb. 5, 1951</u>	<u>Chester Cem.</u>	<u>Chestertown, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb. 4 - 1951</u>	<u>Clara S. Barnes</u>	<u>J. Willis Wells-</u>	<u>Chestertown, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

29011C



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1630
Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown Rural (1 mile)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1 mile south of Chestertown</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Alice</u> (Middle) <u>Middleton</u> (Last) <u>Whitworth</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 12 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>	
11. FATHER'S NAME <u>John Crooks</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Middleton</u>	
15. SOCIAL SECURITY No. <u>none</u>		16. INFORMANT AND ADDRESS <u>Mr. J. B. Whitworth, Chestertown, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hypertensive cardiovascular disease</u>	Antecedent cause(s) (b) <u>442x</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131a</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 1, 1950, to Feb 18, 1951, that I last saw the deceased alive on Feb 18, 1951, and that death occurred at 8:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert W. Farr M.D. ADDRESS Chestertown, Md DATE SIGNED Feb 18, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 20, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem</u>	LOCATION (City, town, or county) (State) <u>Near Chestertown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1631
Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salina</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salina</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>SARAH</u>	(Middle) <u>L.</u>	(Last) <u>WOOD</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>26</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 28/1862</u>
9. AGE last birthday <u>88</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>
11. BIRTHPLACE (State or foreign country) <u>md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>		13. FATHER'S NAME <u>Emory Camp</u>
14. MOTHER'S MAIDEN NAME <u>Susan Wilcox</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>
17. INFORMANT AND ADDRESS <u>Thomas B. Wood Baltimore md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Flu heart failure

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

old age

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) home(CITY OR TOWN) Salina (COUNTY) KentTIME (Month) (Day) (Year) (Hour) OF INJURY 2 26 1957 5 amINJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from 2 24....., 1957....., to 2 26....., 1957....., that I last saw the deceasedalive on 2 26....., 1957....., and that death occurred at 5.....4.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 27, 1957Elizabeth J. MudgettEdward WilcoxSalina Kent md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

